MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

0397 850

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Medford outside
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Medford - Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: ½ mile west of Medford
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Emma Anders

3. (b) Social Security Number: none

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband ~~or wife~~: John Anders
Dead
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Nov 17 1852

8. AGE: Years: 87 Months: 2 Days: 5 If less than one day ____ hrs. ____ min.

9. Birthplace: Fredrick Co Md
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: At home
FATHER
12. Name: Henry Martin
13. Birthplace: Md
MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known
16. Informant: Mrs Elizabeth Martin
Address: Medford Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-24-40 (month) (day) (year)
Cemetery or crematory: Hough Cemetary
Location: Fredrick Co Md
18. Funeral director: D D Hamler & Sons
Address: New Windsor Md
19. Jan 27 40 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22. 1940, at 7 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1939, to Jan 22 1940
and that I last saw her alive on Jan 15 1940
Immediate cause of death: Acute Cardiac Dilatation — DURATION: a few minutes
Due to: Chronic Myocarditis — 1 year
Due to: Arterio-Sclerosis — 3 yrs
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Chas R Fouty M.D.
M. D. or other
Address: Westminster Md — Date signed 1/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

0398

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: John F Arnsberger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Mollie Arnsberger
6(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): May 4 1862

8. AGE:

Years	Months	Days	If less than one day
77	8	20	hrs. min.

9. Birthplace: York Spring Pa.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Daniel Arnsberger
13. Birthplace: Unknown

MOTHER
14. Maiden name: Eliza Mc Mellen
15. Birthplace: Unknown

16. Informant: Mrs. Mollie Arnsberger
Address: Finksburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 27, 1940 (month) (day) (year)
Cemetery or crematory: Ebenezer
Location: Winfield Md.

18. Funeral director: H M Waltz
Address: Winfield. Md

19. 1/26 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24 1940, at 10:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1928 to Jan 24 1940, and that I last saw h[illegible] alive on Jan 23 1940.

Immediate cause of death	DURATION
Acute Hemiplegia	4 days
Due to Cerebral Hemorrhage	
Due to Chronic Hemiplegia	12 yrs.
Other conditions Hypostatic Pneumonia	2 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Beecher Barr M. D. or other
Address: Westminster Md Date signed 1/26/40

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

0399

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Birnie J. Babylon

3. (b) Social Security Number: 219-01-8395

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife: Alleta M. Babylon

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 13, 1877

8. AGE: Years	Months	Days	If less than one day
63	0	16	hrs. min.

9. Birthplace: Md
(Town, county and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: William Babylon
13. Birthplace: Md

MOTHER
14. Maiden name: Amanda Rhodes
15. Birthplace: Md.

16. Informant: Alleta M. Babylon
Address: Taneytown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31-40 (month) (day) (year)

Cemetery or crematory: Keysville

Location: Keysville, Md.

18. Funeral director: Elf Bros & Son

Address: Taneytown, Md.

19. Jan 31, 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29th 1940, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25th 1940, to Jan 29th 1940, and that I last saw him alive on Jan 29th 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 day
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner MD
M. D. or other

Address: Taneytown Md Date signed: Jan 31st 40

RECEIVED
FEB 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0400 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 15 Days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: River Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -- None

3. (a) FULL NAME: Charles Henry Bagley

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

8 (b) Name of husband or wife: ---
6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1916

8. AGE: Years	Months	Days	If less than one day
23	0	18	---hrs. ---min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Caddie
11. Industry or business: ---
FATHER 12. Name: Sherman Alston
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Mary Jergigan
15. Birthplace: Benson, North Carolina
16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 16 1940 (month) (day) (year)
Cemetery or crematory: Lincolnia Memorial Cemetery
Location: Washington D.C.
18. Funeral director: Robert L. Snowden
Address: Rockville Md
19. 1/12/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12, 1940 2:45 P.M. 19, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28, 1939 19 to Jan. 12, 1940 19, and that I last saw him alive on Jan. 12, 1940 19.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1938
Due to: ---	
Due to: ---	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? --- (City or town) --- (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Maryland Date signed: 1/12/40

RECEIVED
FEB 5 1940
BUREAU V-P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (60)

CERTIFICATE OF DEATH

0401

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster Rural mail
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Rural Mail Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sabra Anna Bankert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Jacob H. Bankert
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1857

8. AGE:

Years	Months	Days	If less than one day
82	5	3	hrs. min.

9. Birthplace Hanover, York, Pennsylvania (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Peter Bankert
13. Birthplace Pa.

MOTHER 14. Maiden name Rachael Utz
15. Birthplace Pa.

16. Informant Miss Ella Bankert
Address Westminster, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16, 1940 (month) (day) (year)

Cemetery or crematory Kridler
Location Near Westminster, Md.

18. Funeral director H. Bankard & Son
Address Westminster, Maryland

19. 1-16-1940 (Date rec'd by registrar) C. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13th 1940, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5th 1940, to Jan. 12th 1940, and that I last saw her alive on Jan. 12th 1940.

Immediate cause of death	DURATION
Acute Bronchitis	10 days
Hypostatic Pneumonia	3 days
Due to Chronic myocarditis	10 yrs.
Due to Large untreated carcinoma of right breast (ulcerated)	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Billingsley M. D. or other
Address Westminster, Md. Date signed 1/13/40

RECEIVED
FEB 8 1940
BUREAU V. S.

0402

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95C)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Near Gamber
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 14 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Near Gamber Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. D. Westminster
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Bessie M. Barber

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harry Barber

6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1881

8. AGE: Years: 58 Months: 4 Days: If less than one day: hrs. min.

9. Birthplace: Winfield
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Home

FATHER
12. Name: Thomas Fossett
13. Birthplace: Carroll Co.

MOTHER
14. Maiden name: Clara Stimel
15. Birthplace: Carroll Co.

16. Informant: Harry Barber
Address: Westminster

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jan 8, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant Cemty.

Location: Gamber

18. Funeral director: C. M. Waltz
Address: Winfield Md.

19. 1/6 1940 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5 1940, at 1:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1939, to Jan. 5 1940, and that I last saw her alive on Dec. 30 1939.

Immediate cause of death: Heart disease

Due to: arteriosclerosis

Due to: Hypertensive vascular disease

Other conditions: mental depression. Gall stones removed Sept. 4, 1939
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Reese Wilkens, M.D.
M. D. or other

Address: Westminster, Md. Date signed: Jan 6, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0403

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 5 months 1 day
Stay in this community (yrs., or mos., or days) (Same as above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ~~Talbot~~ Queen Anne
City or town ~~Easton~~ Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ~~119 Board St.~~
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Viola Barber

3. (b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife --
6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1918

8. AGE: Years	Months	Days	If less than one day
21	0	17	---hrs. ---min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business --

FATHER
12. Name Clarence Barber
13. Birthplace unknown

MOTHER
14. Maiden name Arine Thompson
15. Birthplace Baltimore, Md.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 6 1940 (month) (day) (year)
Cemetery or crematory Mt Auburn
Location Balto Md
18. Funeral director Mrs Katie R Williams
Address 322 n Lemmon st

19. Jan. 3, 1940 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1940 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2, 1939 to Jan. 3, 1940
and that I last saw her alive on Jan. 3, 1940

Immediate cause of death Pulmonary Tuberculosis — DURATION April 1938
Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 1/3/40

Authorization to change place of residence of deceased filed in permanent file under McCallum 4/8/40 B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

0404

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
123 E. main St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 11

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 123 E. main
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maggie Lucretia Barnes

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Richard Wesley Barnes
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 20 - 1868

8. AGE:

Years	Months	Days	If less than one day
71	11	8	____ hrs. ____ min.

9. Birthplace Louisville, Carroll, Maryland (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Charles F. Brauning
13. Birthplace Germany
MOTHER 14. Maiden name Rebecca Cook
15. Birthplace Reisterstown, Maryland
16. Informant W. Hammond Barnes
Address 123 E. Main St. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1940 (month) (day) (year)
Cemetery or crematory Mt. Pleasant Cemetery
Location Gamber Carroll Co. Maryland
18. Funeral director H Bankard & Son
Address Westminster Maryland
19. 1/25 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28th 1940, at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1st 1939, to Jan. 28th 1940, and that I last saw her alive on Jan. 28th 1940.

Immediate cause of death acute dilatation of Heart — DURATION Few minutes
Due to Chronic myocarditis — 5 yrs
Due to ____
Other conditions ____
(Include pregnancy within 3 months of death)
Major findings:
Of operations ____
Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE C. J. Billingslea M. D. or other
Address Westminster Md. Date signed 1/24/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 58-21

CERTIFICATE OF DEATH

0405

Reg. Dist. No. 82

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Carroll

City or town Rural - Harrisville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural nr. Harrisville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. #4 Mt. Airy, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None.

3. (a) FULL NAME John M. Baumgardner

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Pearl Baumgardner

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 13, 1876

8. AGE: Years	Months	Days	If less than one day
63	9.	8	____ hrs. ____ min.

9. Birthplace Frederick Co. Maryland.
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER 12. Name Solomon B. Baumgardner

13. Birthplace Maryland.

MOTHER 14. Maiden name Elizabeth Stambaugh

15. Birthplace Maryland.

16. Informant Mrs. Pearl Baumgardner.

Address R.D. Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1940 (month) (day) (year)

Cemetery or crematory Pine Grove

Location Mt. Airy, Md

18. Funeral director C.M. Waltz

Address Winfield, Md

19. Jan 23 1940 (Date rec'd by registrar) Thos. D. Seigford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1939, to Jan 21 1940, and that I last saw him alive on Jan 21, 1940.

Immediate cause of death	DURATION
Acute Myocardial Insufficiency	8 hrs.
Due to Acute Inflamatory Rheumatism	1 wk.
Due to Extensive local infection of left hand	4 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other

Address Mt. Airy Md Date signed 1/22/40

RECEIVED
FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

0406

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Smallwood (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Smallwood Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Marion Bitzel

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Lillie Frick Bitzel

6(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov. 26. 1879

8. AGE: Years	Months	Days	If less than one day
60	1	9	hrs. min.

9. Birthplace Smallwood Carroll, Maryland (Town, county, and state)

10. Usual occupation Farmer own farm

11. Industry or business

FATHER 12. Name Charles Henry Bitzel

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Crooke

15. Birthplace Maryland

16. Informant Mrs Carroll Frock

Address Smallwood. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8 1940 (month) (day) (year)

Cemetery or crematory Trinity Lutheran

Location Deer Park Road

18. Funeral director H Bankard & Son

Address Westminster, Maryland

19. (Date rec'd by registrar) 1-5-1940 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5th 1940, at 9.0 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Jan. 1st 1938, to Jan. 5th 1940, and that I last saw him alive on Jan 4th 1940.

	DURATION
Immediate cause of death Uraemia Coma	
Due to Chronic Glomerulonephritis	2 yr.
Due to	
Other conditions Diabetes	2 yr.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. J. Billingslea M. D. or other

Address Westminster, Md. Date signed 1/5/40

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

0457

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: R.F.D. Mt Airy Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Brown

3. (b) Social Security Number: None

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife: Infant

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years | Months | Days | If less than one day: hrs. 0 min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: None

FATHER
12. Name: Preston L Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Vida O Watkins
15. Birthplace: Maryland

16. Informant: Mrs Vida O Brown
Address: R.F.D. Mt Airy Md

17. Family disposal (Burial, cremation, or removal. Which?) Date thereof Jan 30-40 (month) (day) (year)

Cemetery or crematory: None

Location:

18. Funeral director: None. Family disposal
Address:

19. Jan. 30 1940 (Date rec'd by registrar) Wm D Snyder (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1940, to Jan 30 1940, and that I last saw him alive on Jan 30 1940.

Immediate cause of death: Premature Delivery (4 months) — DURATION: 4 mos

Due to: Fall on ice — Jan 29

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: C. M. Van Pagle
M. D. or other
Address: Mt Airy Md — Date signed 1-30-40

FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (109)

CERTIFICATE OF DEATH

0408

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural N Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Louise Brown

3. (b) Social Security Number

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11, 1939

8. AGE: Years 1 Months — Days 13 If less than one day hrs. min.

9. Birthplace Mt. Westminster Carroll, Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden name Evelyn Brown
15. Birthplace Maryland

16. Informant Mrs William Brown
Address Westminster Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan. 26. 1940
(month) (day) (year)

Cemetery or ~~crematory~~ Meadowbranch

Location Mt. Westminster, Maryland.

18. Funeral director H. Bankard & Son
Address Westminster Md.

19. 1/25 1940 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24th 1940, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1940, to Jan 23 1940, and that I last saw her alive on Jan. 23 1940.

Immediate cause of death Broncho Pneumonia, primary.

DURATION

Due to There was no associated disease. [illegible]

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J Stewart M. D. or other

Address Westminster Md Date signed Jan 24 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) I

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0409

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Patapsco
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 38 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Patapsco Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ethel A. Caple

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Arthur F. Caple

6(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): July 18, 1901

8. AGE:

Years	Months	Days	If less than one day
38	5	21	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Elmer Taylor
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura J. Blizzard
15. Birthplace: Maryland

16. Informant: Arthur F. Caple
Address: Patapsco, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/40 (month) (day) (year)

Cemetery or crematory: Bethel Church of God

Location: Carrollton, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 1/10/1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8, 1940, et M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 12 1939, to Jan 8 1940, and that I last saw h alive on Jan 8 1940

Immediate cause of death	DURATION
Acute Cardiac dilatation.	3 hours
Due to Carcinoma of uterus	about 10 or 11 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Laboratory diagnosis

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas R Fouty M D
M. D. or other

Address: Westminster Md Date signed: Jan 9 1940

RECEIVED
FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0410

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs 8 mo

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Howard

City or town: Ellicott City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rest Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mary Justina Carlin

3. (b) Social Security Number: —

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward Carlin

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 31st 1885

8. AGE: Years 55 | Months | Days 18 | If less than one day ___ hrs. ___ min.

9. Birthplace: Baltic Co
(Town, county, and state)

10. Usual occupation: not any

11. Industry or business

FATHER
12. Name: John Rest
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Hartman
15. Birthplace: Frederick Co Md

16. Informant: Edward Carlin
Address: Ellicott City Md

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof: Jan. 21, 1940 (month) (day) (year)

Cemetery or crematory: St. Johns

Location: Ellicott City, Md.

18. Funeral director: E. S. MacNabb

Address: Catonsville Md

19. Jan. 20 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19th 1940, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1938, to Jan 19 1940, and that I last saw her alive on Jan 19th 1940.

Immediate cause of death	DURATION
Bronho Pneumonia	Jan 19-40
Due to	
~~Due to~~ Paralysis Agitans	1936
Other conditions: Arterio Sclerosis (Include pregnancy within 3 months of death)	1917

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. J. Martin M.D.
M. D. or other

Address: Sykesville Md Date signed: Jan 19-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

JAN 26 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

0413

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Springville Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 5 yrs., 4 mos., 6 Days

Stay in this community (yrs., or mos., or days): 5 yrs., 4 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 931 Luzerne Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Agnes Bridget Clark

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: Years: 74 | Months: — | Days: — | If less than one day: ___ hrs. ___ min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: John Clark

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: Ireland

16. Informant: Mary A. Connell

Address: 931 Luzerne Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29 1940 (month) (day) (year)

Cemetery or crematory:

Location: Baltimore Md.

18. Funeral director: John J. Fahey Sons

Address: 1618 Light St.

19. Jan. 27 1940 (Date rec'd by registrar) C. Stanley Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27th 1940, at 2-15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1938, to Jan 27 1940, and that I last saw her alive on Jan 27th 1940.

	DURATION
Immediate cause of death: Hypostatic pneumonia	2 days
A. Arteriosclerosis, generalized	Sep., 1934 (Known)
Due to: Arteriosclerotic heart disease	Sep., 1934 (Known)
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: Jan. 27, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Street address added from information given in person by the informant - 2-16-40 as.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46-d) ✓

CERTIFICATE OF DEATH

0412

Reg. Dist. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Rural near Hampstead
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 67 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Hampstead Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura V Davidson
3. (b) Social Security Number None

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or ~~wife~~ Joel W Davidson
6(c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) November 11-1872
8. AGE: Years 67 Months 2 Days 8 If less than one day ___ hrs. ___ min.
9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Columbus Elseroad
13. Birthplace Maryland
MOTHER 14. Maiden name Ellen S Annacost
15. Birthplace Maryland
16. Informant Mrs Samuel Stansfield
Address Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22/40 (month) (day) (year)
Cemetery or crematory Wesley Methodist
Location Near Hampstead, Md
18. Funeral director Edw C Tipton
Address Hampstead Md
19. Jan 20 1940 (Date rec'd by registrar) John S. Hughes, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1940, at 3 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 27 1938, to Jan 19 1940 and that I last saw her alive on Jan 19, 1940 19
Immediate cause of death Gangrene of Pneumonia
Carcinoma of Rectum
Due to C Metastasis
Due to
Other conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations Same.
Of autopsy None Done

DURATION 2 yrs

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph E. Bush M.D. M. D. or other
Address Hampstead Md Date signed 1-19-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0413

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 22 Days
Stay in this community (yrs., or mos., or days) (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. George
City or town Croom Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Henry Ford

3. (b) Social Security Number: Ross.-214-10-3570

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Unknown
6(c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) Oct. 15, 1911

8. AGE: Years 28 | Months 3 | Days 10 | If less than one day ___ hrs. ___ min.

9. Birthplace Croom, Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business --

FATHER
12. Name John Ford
13. Birthplace Croom, Md.

MOTHER
14. Maiden name Lucy Stewart
15. Birthplace Croom, Md.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-27-40 (month) (day) (year)
Cemetery or crematory St. Lukes Cemetery
Location Sykesville Md
18. Funeral director Harry Weer
Address Sykesville Md.

19. 1/25/40 (Date rec'd by registrar) 19 Albert R. Swankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1940 19 9:35 A.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3, 1940 19 to Jan. 25, 1940 19
and that I last saw him alive on Jan. 25, 1940 19

Immediate cause of death: Pulmonary Tuberculosis
Due to --
Due to --
Other conditions --
(Include pregnancy within 8 months of death)
Major findings:
Of operations --
Of autopsy No Autopsy

DURATION: Nov. 1938

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 1/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0414

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 5 months 2 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1634 E. Preston St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Edward Gibson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: --

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Jan. 17, 1921

8. AGE:

Years	Months	Days	If less than one day
19	0	4	____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: ---

FATHER
12. Name: James Edward Gibson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Chase
15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/3/40 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: A. A. County Md.

18. Funeral director: Joseph G. Locke, Jr.
Address: 1304 N. Central Ave.

19. 1/31/40 (Date rec'd by registrar) Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31, 1940 19__, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29, 1939 19__ to Jan. 31, 1940 19__, and that I last saw him alive on Jan. 31, 1940 19__

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1939

Due to: --

Due to: ---

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) -- (County) -- (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 1/31/40

RECEIVED
FEB 15 1940
BUREAU V. S.

0415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH:

County: Carroll

City or town: Rural m. Taylorsville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 24 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural m. Taylorsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. # Westminster, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: James Green

3. (b) Social Security Number: No.

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1878

8. AGE: Years: 62 Months: 0 Days: 16 If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farming.

FATHER
12. Name: Perry Green
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Ellen Long
15. Birthplace: Maryland

16. Informant: Mr. Clarence Wright

Address: R.D. Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20, 1940 (month) (day) (year)

Cemetery or crematory: Taylorsville

Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C.M. Waltz.

Address: Winfield Md

19. Jan. 19 1940 (Date rec'd by registrar) E.M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17, 1940, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1940, to Jan 17 1940, and that I last saw him alive on Jan 17 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: — one

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: Jas. T. Thorne M.D.
M. D. or other

Address: New Windsor Md Date signed: 1-19-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0416

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 25 yr. 7 mo. 27 days
Stay in this community (yrs., or mos., or days): 25 yr. 7 mo. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 735 Newington Avenue
(If rural give LOCATION)
(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William W. Hampson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years: 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Builder

11. Industry or business: Building

FATHER
12. Name: Joseph Hampson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Sheck
15. Birthplace: Maryland

16. Informant: Hospital record
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 1 1940 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto. Md.

18. Funeral director: C. W. Tomlinson
Address: 1003 W. Balto. St.

19. Jan. 30 1940 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30, 1940 19 11:50 a. at m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1938, to January 30 1940, and that I last saw him alive on January 30, 1940.

Immediate cause of death	DURATION
Bronchopneumonia	one month
Due to ?	
Due to	
Other conditions: Dementia praecox paranoid type, duration 25 yr. (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Samuel Barkoff M.D. (M.D. or other)
Address: Sykesville, Md. Date signed 1/30/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0417

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME James J Hill

3. (b) Social Security Number none

4. Sex: M
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edna E. Hill
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept 21, 1868
8. AGE: Years 71 | Months 4 | Days 5 | If less than one day hrs. min.
9. Birthplace Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Henry Hill
13. Birthplace Md
MOTHER 14. Maiden name Louisa Butler
15. Birthplace Md
16. Informant Mrs Edna E. Hill
Address Taneytown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29, 1940 (month) (day) (year)
Cemetery or crematory St Joseph's
Location Taneytown Md
18. Funeral director C O Shaum & Son
Address Taneytown, Md
19. Jan 28 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1940, at 11:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 14 1940, to Jan 22 1940, and that I last saw him alive on Jan 22 1940.

Immediate cause of death	DURATION
Cancer of Liver	1 yr.
Due to	
Due to	
Other conditions Prostate extensive metastasis.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D.
M. D. or other
Address Taneytown, Md Date signed 1/28/40

RECEIVED
FEB 2 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

0418

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, ~~hospital, or institution~~ 48 Liberty St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harvey M. Hiltabridle

3. (b) Social Security Number

4. Sex M | 5. Color or race W | 6.(a) Single, married, widowed, or divorced Married

B (b) Name of husband or wife Flora E. Hiltabridle

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 7, 1872

8. AGE: Years 67 | Months 4 | Days 30 | If less than one day ____ hrs. ____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business

FATHER 12. Name Noah Hiltabridle

13. Birthplace Md

MOTHER 14. Maiden name Penelope Stricklin

15. Birthplace Md

16. Informant Mrs Flora E. Hiltabridle
Address 48 Liberty St.

17. Burial (Burial, cremation, or removal—which?) Date thereof Jan 9, 1940 (month) (day) (year)

Cemetery or crematory Baust
Location near Tyrone, Md

18. Funeral director C. D. Bussard Son
Address Taneytown, Md

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1939, to Jan 6 1940, and that I last saw him alive on Jan 6 1940

	DURATION
Immediate cause of death Pyelo-Nephritis	Dec 1939
Due to Prostatic Hypertrophy	1938
Due to Senility	
Other conditions Arterio-Sclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Spreicher M. D. or other
Address Westminster Date signed Jan 8/40

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0419

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton,
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sabatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 Mo's. 25 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Bowie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: James Alfonza Holland

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan., 19, 1935

8. AGE:

Years	Months	Days	If less than one day
4	11	25	____ hrs. ____ min.

9. Birthplace: Anne Arundel County, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: At home

FATHER
12. Name: John Holland
13. Birthplace: Bowie, Md.

MOTHER
14. Maiden name: Estell Harrison
15. Birthplace: Anne Arundel Co., Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15-40 (month) (day) (year)

Cemetery or crematory: Fork Ch AA Co Md

Location: AA Co Md

18. Funeral director: M Flading Sons

Address: Bowie Md

19. 1/13/40 (Date rec'd by registrar) 19 Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1940, at 12.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 1939, to Jan., 13, 1940, and that I last saw him alive on January 13, 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 4th 1939

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? ---- (City or town) ---- (County) --- (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: ---- Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 1/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

FEB 1 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0420

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 2 years 19 days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Turners Station Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Balneu, Maryland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lloyd McGill Holmes

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife ---
6(c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) April 12, 1923

8. AGE: Years 16 | Months 9 | Days 3 | If less than one day ___ hrs. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business —
FATHER
12. Name Joseph Holmes,
13. Birthplace Virginia
MOTHER
14. Maiden name Lillie Joyner
15. Birthplace Virginia
16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 17-1940 (month) (day) (year)
Cemetery or crematory Isle of Wight
Location Smithfield. Va
18. Funeral director James A Hayes
Address 142 W Hill St
19. Jan. 15, 1940 (Date rec'd by registrar) Albert R Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1940 7:05 A.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27, 1937 19 , to Jan. 15, 1940 , and that I last saw him alive on Jan. 15, 1940 19

Immediate cause of death Pulmonary Tuberculosis — DURATION Nov. 1937
Due to ---
Due to ---
Other conditions --
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide --- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 1/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0421

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 mo. 17 days

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 457 Washington Square (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Walter Hook

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bertheuer Dyche

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1903

8. AGE:

Years	Months	Days	If less than one day
36	11	21	hrs. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Lo. P. A.

11. Industry or business

FATHER 12. Name John Hook

FATHER 13. Birthplace West Virginia

MOTHER 14. Maiden name Emily Bell

MOTHER 15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10/40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Hagerstown, Md.

18. Funeral director Fred Dr. Kaiser

Address Hagerstown Md.

19. Jan. 7 1940 C. Nancy Wear (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1940, at 7:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 1939, to January 7 1940, and that I last saw him alive on January 6 1940

Immediate cause of death	DURATION
General Paralysis of the Insane	1937
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. M. D. or other

Address Sykesville, Md. Date signed Jan. 7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 29 1940
BUREAU V. S.

0422

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural near Westminster, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: x

Stay in hospital or inst. (yrs., or mos., or days) x

Stay in this community (yrs., or mos., or days) about 12 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Rural near Westminster ~~Ward No.~~
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Washington Rd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR x

3. (a) FULL NAME Mary Elizabeth Hunter

3. (b) Social Security Number None

4. Sex female

5. Color or race white

6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband ~~or wife~~ Joseph T. Hunter deceased

6(c) If alive, give age x years

7. Birth date of deceased (mo., day, yr.) Jan. 20th 1850

8. AGE: Years 90 Months 11 Days 29 If less than one day ___ hrs. x ___ min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual occupation x invalid

11. Industry or business —

FATHER
12. Name Jacob Copersmith
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Zenith Copersmith
15. Birthplace Carroll Co. Md.

16. Informant Mr. Joseph E. Hunter
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 22 40 (month) (day) (year)

Cemetery ~~or crematory~~ Kriders

Location near Westminster, Md.

18. Funeral director J. E. Myers Jr.
Address Westminster, Md.

19. 1/20 1940 L K Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 19th 1940, at 6 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8th 1940 to Jan 19th 1940, and that I last saw her alive on Jan 18th 1940 (Ambulatory)

Immediate cause of death Coronary Occlusion — DURATION 10 mins.

Due to Arterio Sclerosis — 10 yrs

Due to

Other conditions Acute Bronchitis — 12 days

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? ___ (City or town) ___ (County) ___ (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ___ Injured at work?

23. SIGNATURE L K Woodward M.D.
M. D. or other

Address Westminster Date signed 1/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0423

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 Yrs. 7 Mos. 25

Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: Centreville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Das. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: William Thomas James, Jr.

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Hester James

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1911

8. AGE:

Years	Months	Days	If less than one day
28	2	25	---hrs. ---min.

9. Birthplace: Centreville, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: William Thomas James
13. Birthplace: Centreville, Md.

MOTHER
14. Maiden name: Hester Morris
15. Birthplace: Centreville, Md.

18. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29 1940 (month) (day) (year)

Cemetery or crematory: Cemetery.

Location: Brownsville Md.

18. Funeral director: Barton Brothers.

Address: Centerill Md.

19. 1/26/40 (Date rec'd by registrar) 19 Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26, 1940 19---, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31, 1937 19---, to Jan. 26, 1940 19---, and that I last saw him alive on Jan. 26, 1940 19---.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan., 1937
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? --- (City or town) --- (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Date signed 1/26/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

0424

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town near Manchester Md (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 62 - 2 - 29

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Near Manchester Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emma L. Keck

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct. 14, 1870
8. AGE: Years 69 Months 2 Days 29 If less than one day hrs. min.
9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual occupation House Work
11. Industry or business
FATHER 12. Name Philip Keck
13. Birthplace Germany
MOTHER 14. Maiden name Christiana Hirsch
15. Birthplace Germany
16. Informant Charles Keck
Address Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-40 (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Manchester Md
18. Funeral director Jacob Wink's Sons
Address Manchester Md
19. Jan. 14 1940 Mrs. H. J. L. Dessner (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1940, at 9A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1939, to Jan 13 1940, and that I last saw h-er alive on Jan 11 1940.

	DURATION
Immediate cause of death: Cardio Vascular renal disease	13 mos
Due to	
Due to	
Other conditions: Uremia	1 week

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William R & Dessner M. D. or other
Address Manchester Md Date signed 1/14/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0425

Reg. Dist. No. 24

1. PLACE OF DEATH
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 13 yrs., 6 mos., 9 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 21 Penn Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
Ernest E. Keegan

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: Elsie M. Keegan
6(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): July 3rd, 1875
8. AGE: Years: 64 Months: 6 Days: 7 If less than one day: ____ hrs. ____ min.
9. Birthplace: England (Town, county, and state)
10. Usual occupation: Brick layer
11. Industry or business: Brick layer
FATHER 12. Name: James Keegan
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Margaret Hennessey
MOTHER 15. Birthplace: Ireland
16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 12 1940 (month) (day) (year)
Cemetery or crematory Prospect Hill Cemetery
Location Towson Balto Co Md
18. Funeral director William Cook
Address 1217 St Paul St Balto Md
19. Jan 10 1940 (Date rec'd by registrar) C Harry Weil Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10th 1940, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st, 1926 to Jan. 10th, 1940, and that I last saw him alive on January 9th, 1940

Immediate cause of death: Cancer of digestive tract, probably head of the pancreas. — DURATION: Prior to 1/7/40

Due to

Due to

Other conditions: Dementia Praecox, Paranoid type (Include pregnancy within 3 months of death) — 1923

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Burk M.D.
M. D. or other

Address Springfield State Hospital Date signed Jan 10 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 5 1910
BUREAU V. S.

0426

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 15 John St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 15 John St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry Michael Koontz

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of ~~husband~~ or wife Maria (Bair) Koontz

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13 - 1851

8. AGE: Years 88 Months 5 Days 11 If less than one day hrs. min.

9. Birthplace Silverrun, Carroll, Maryland (Town, county, and state)

10. Usual occupation Farmer Retired

11. Industry or business

FATHER 12. Name Henry Koontz

13. Birthplace Maryland

MOTHER 14. Maiden name Sarah Crouse

15. Birthplace Maryland

16. Informant Mrs William Breitweiser

Address 15 John St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 27, 1940 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Maryland

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 25 1940 (Date rec'd by registrar) J. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1940, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1940 to Jan 24 1940, and that I last saw him alive on Jan 24th 1940.

Immediate cause of death Bronchopneumonia La Grippe

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. ~~or other~~ 1940

Address Westminster Md. Date signed Jan 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
FEB 6 1940
BUREAU V. S.

0427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:

County Carroll

City or town Rural N. New Windsor Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural N New Windsor Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Jordan's Retreat

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME William Leonard Kress

3. (b) Social Security Number No

4. Sex M

5. Color or race W.

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Agusta Kress

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 8, 1858

8. AGE: Years 81 Months 6 Days 27 If less than one day ___ hrs. ___ min.

9. Birthplace Carroll County Md (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Conrad Kress

13. Birthplace Germany

MOTHER 14. Maiden name Catherine Lehr

15. Birthplace Germany

16. Informant Mrs. Sarah Pittinger

Address New Windsor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7-40 (month) (day) (year)

Cemetery or crematory Louis Creek Church of Brethren

Location Dennings, Carroll Co.

18. Funeral director C. M. Waltz

Address Winfield Md

19. Jan 7 1940 (Date rec'd by registrar) Ernest S. Bradley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1940, at 1:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2-40 to Jan 5 1940, and that I last saw him alive on Jan 4 1940.

Immediate cause of death Broncho-Pneumonia

Due to Arterio-Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

DURATION 8 days

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh M. D. M. D. or other

Address New Windsor Md Date signed 1-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

(M)

0428

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH 95c

County Carroll Registration Dist. No. 70

Village or City Mr. Mayberry No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Vincent V. Lahman If U. S. Veteran, specify WAR World War

(a) Residence: No. St., Ward no social security number

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel T. Lahman

6. DATE OF BIRTH (month, day, and year) Aug 15, 1898

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Chauffer +

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Brakeman B+O.

10. Date deceased last worked at this occupation (month and year) 1916

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) W. Va

FATHER

13. NAME G. D. Lahman

14. BIRTHPLACE (city or town) (State or country) W. Va.

MOTHER

15. MAIDEN NAME Laura Leese

16. BIRTHPLACE (city or town) (State or country) W. Va.

17. INFORMANT (Address) Ethel T. Lahman Westminster, Md R.D.

18. BURIAL, CREMATION, OR REMOVAL Lutheran Taneytown Jan. 23, 1940

19. UNDERTAKER (Address) C. Duas Bon Taneytown, Md.

20. FILED Jan 22, 1940 Ethel M Mehring Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 18 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

I last saw h elive on , 19 ; death is said to have occurred on the date stated above, at 9:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Date of onset

~~Heart~~ Condition Do to Injuries Received while in the army

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) R. F. Wells M. D.

(Address) Taneytown Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

0429

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown R.D.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Catherine M. Lloyd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife George Lloyd

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1858

8. AGE: Years	Months	Days	If less than one day
81	8	11	hrs. min.

9. Birthplace Balto (Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name Peter Henry

13. Birthplace Md.

MOTHER 14. Maiden name Margaret Platt

15. Birthplace Md.

16. Informant Mr. George P. Martell

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1940 (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Balto. Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. Jan 12, 1940 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1940, at 5-30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 11 1937, to Jan. 10 1940, and that last saw her alive on Jan. 9 1940

Immediate cause of death General Senile -

Due to Arterio Sclerosis

Due to

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings:

Of operations ✓

Of autopsy ✓

DURATION

History of 15 yrs.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ✓

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓

Means of injury ✓ Injured at work? ✓

23. SIGNATURE C. A. Stultz M.D. M. D. or other

Address Woodsboro Md. Date signed 1-10-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 2 1960
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0430

Reg. Dist. No. 83

1. PLACE OF DEATH:

County Carroll.

City or town Rural near Berrett.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll.

City or town Rural nr. Berrett Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. Sykesville
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James E. Lyles

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1933

8. AGE: Years 6 Months 1 Days 8 If less than one day hrs. min.

9. Birthplace Frederick, Fred. Co. Md.
(Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER
12. Name Wilbur Lyles
13. Birthplace Maryland.

MOTHER
14. Maiden name Grace Hackett.
15. Birthplace Maryland.

16. Informant Mrs. Grace Hammond.

Address R.D. Sykesville, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Jan. 17, 1940
(month) (day) (year)

Cemetery or crematory White Rock Cemty

Location near Berrett, Carroll Co. Md.

18. Funeral director C.M. Waltz

Address Winfield Md.

19. Jan 17 1940 Edna M. Hewitt
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1940, 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19

Immediate cause of death

Laryngeal polypi; duration several years.

Acute Congestive Heart failure

Due to C. Pulmonary edema.

There was no preceding heart disease.

Due to Laryngeal Polypi

Laryngeal ~~paralysis~~; duration, several years.

Other conditions ~~Polypi~~;

Was ill cared for, and ill nourished.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

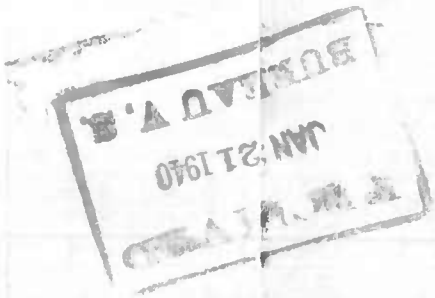
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 1-16-40


JAN 21 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

0431

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Near Taneytown Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George P Martell

3. (b) Social Security Number Non

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Louisa J Martell

6(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Feb 3 - 1868

8. AGE: Years 71 | Months 11 | Days 20 | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Peter Martell

13. Birthplace Md

MOTHER 14. Maiden name Barbara Hoffler

15. Birthplace Germany

16. Informant Louisa J Martell

Address Taneytown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1940 (month) (day) (year)

Cemetery or crematory Lutheran Taneytown Md

Location

18. Funeral director C A Russ & Son

Address Taneytown Md

19. Jan. 25 1940 (Date rec'd by registrar) Ethel M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1940, at 4:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8 1939, to Jan. 22 1940, and that I last saw him alive on Jan. 22 1940.

Immediate cause of death	DURATION
Chronic Myocarditis and	
myocardial degeneration	2 Yrs.
Due to	
Due to	
Other conditions Chronic Nephritis	10 Yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.
M. D. or other

Address Taneytown Md Date signed Jan 23, 1940

RECEIVED
FEB 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0432

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 2 yrs., 5 mos., 16 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland. County
City or town Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 520 South Duncan.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Marion Mazyiwski. (majewski) **(b) Social Security Number** none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Married.

6 (b) Name of husband or wife Unknown.
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Exact date unknown.

8. AGE: Years	Months	Days	If less than one day
75(?)	#	#	____ hrs. ____ min.

9. Birthplace Poland. (Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business General.
FATHER 12. Name Unknown.
13. Birthplace Poland.
MOTHER 14. Maiden name Unknown.
15. Birthplace Poland.
16. Informant Springfield Hospital Record.
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/26/40 (month) (day) (year)
Cemetery or crematory Holy Rosary Cem
Location Balto. County
18. Funeral director John M. Welby
Address 601 S. Chester Street
19. Jan. 23 1940 C. Harry Weer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1940, at 11 30 P.M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept. 24, 1937, to Jan. 22, 1940, and that I last saw him alive on Jan. 22, 1940.

Immediate cause of death	DURATION
Broncho-Pneumonia	1-11-40.
Due to	
Due to	
Other conditions Cerebral Arterio-sclerosis prior to (Include pregnancy within 3 months of death)	8-6-37.

Major findings:
20f operations
20f autopsy No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D., M. D. or other
Address Sykesville, Md. Date signed 1-23-40.

JAN 29 1940
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

0433

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 6 months, 26 days

Stay in this community (yrs., or mos., or days): Same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 3227 Burleith Avenue
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No record

3. (a) FULL NAME: Philip Myer Miller

3. (b) Social Security Number: Ross-321-09-0182

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Bessie Lappin

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years	Months	Days	If less than one day
62	?	?	____ hrs. ____ min.

9. Birthplace: Odessa, Russia
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: General Merchandise

FATHER
12. Name: George Miller
13. Birthplace: Russia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Russia

16. Informant: Springfield State Hospital records,
Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9, 1940 (month) (day) (year)

Cemetery or crematory: Windsor Mill Road

Location: Baltimore Md.

18. Funeral director: Jack Lewis Inc.

Address: 1439 E. Baltimore St.

19. Jan. 8 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8th 1940, at 2:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12th 1939, to Jan. 8th, 1940, and that I last saw him alive on January 7th 1940.

Immediate cause of death: Cerebral arteriosclerosis

DURATION: Aug., 1938

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Samuel Barkoff MD
M.D. or other

Address: Sykesville, Md Date signed: 1/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 12 1940
BUREAU V, S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0434

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll.

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 4 mos.

Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Charles

City or town: ✓ Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: ✓
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Joseph M. Murray.

3. (b) Social Security Number:

4. Sex: Male.

5. Color or race: White.

6. (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1877 or 1878.

8. AGE: Years: 63. Months: Unk. Days: Unk. If less than one day: hrs. min.

9. Birthplace: Charles Co., Md.
(Town, county, and state)

10. Usual occupation: Farm helper.

11. Industry or business:

FATHER
12. Name: John T. Murray.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Ida Jamison.
15. Birthplace: Maryland.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/24/40 (month) (day) (year)

Cemetery or crematory: St. Peters

Location: Waldorf, Md.

18. Funeral director: Huntt & Ryon

Address: Waldorf, Md.

19. Jan. 23 1940 (Date rec'd by registrar) Harry Weer, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 1940, at 4.45 p. M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept. 22, 1938, to Jan. 22, 1940, and that I last saw him alive on Jan. 22, 1940.

Immediate cause of death: Pulmonary Tuberculosis prior to 9-22-'38. DURATION

Due to

Due to

Other conditions: Broncho-Pneumonia 1-12-40.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Harry F. Baer, M. D., M. D. or other
Address: Sykesville, Md. Date signed: 1-22-40.

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

0435

Reg. Dist. No. 72.

1. PLACE OF DEATH:

County Carroll

City or town Pleasant Valley

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Alice C. Myers

3. (b) Social Security Number None

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Upton H. Myers

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1863

8. AGE: Years 76 Months 4 Days 13 If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Egra Motter

13. Birthplace Md

MOTHER 14. Maiden name Catherine Boose

15. Birthplace Md

16. Informant Mrs. Edward Wantz

Address Westminster R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1940 (month) (day) (year)

Cemetery or crematory Pleasant Valley

Location Pleasant Valley Md

18. Funeral director C. Duss & Son

Address Taneytown Md.

19. Jan. 9th 1940. (Date rec'd by registrar) Calvin E. Bankert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7th 1940, at 8:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5th 1940, to Jan 7th 1940, and that I last saw her alive on Jan 7 1940.

Immediate cause of death Bronchial Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J Stewart M. D. or other

Address Westminster Date signed Jan 8 1940

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0436

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 11 Mos. 23 Das.
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 16 Obrian St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Marveyno Parker

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

8 (b) Name of husband or wife: ---

8 (c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): March 2?, 1922

8. AGE:

Years	Months	Days	If less than one day
17	10	9	---hrs. ---min.

9. Birthplace: Annapolis, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER
12. Name: William Parker
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Estella Thomas
15. Birthplace: Davidsonville, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 4/1939 (month) (day) (year)
Cemetery or crematory: Brown Hill
Location: Annapolis
18. Funeral director: J. B. Coffman
Address: Annapolis

19. 1/31/40 (Date rec'd by registrar) 19 Albert R. Swankhorn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31, 1940 9:00 A.M. (19, at, M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEB. 8, 1939 19, to Jan. 31, 1940, and that I last saw her alive on Jan. 31, 1940 19.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1938
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Dt operations: ---
Dt autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Maryland Date signed: 1/31/40

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0437

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 23 Days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 115 South St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Booze Phelps

3. (b) Social Security Number: 487-07-7739 None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): July 27, 1906

8. AGE:

Years	Months	Days	If less than one day
33	5	25	---hrs. ---min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Bar Tender

11. Industry or business: Unknown

FATHER
12. Name: Charles Phelps
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Anna Booze
15. Birthplace: Annapolis, Md.

16. Informant: Dr. Rauben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-23-1940 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Brewer Hill Annapolis

18. Funeral director: Chas. A. Alexander

Address: 43-45 Market at Annapolis

19. 1/20/40 (Date rec'd by registrar) 19 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20, 1940 3:25 P.M. 19---, et---M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28, 1939 19--- to Jan. 20, 1940 19---, and that I last saw him alive on Jan. 20, 1940 19---.

Immediate cause of death	DURATION
Bulmonary Tuberculosis	May 1939
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? --

23. SIGNATURE: Rauben Hoffman M.D.
M. D. or other

Address: Henryton, Md. Date signed 1/20/40

RECEIVED
JAN 27 1940
LAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98-2)

0438

CERTIFICATE OF DEATH

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town New Windsor

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 10 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town New Windsor Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Carrie Elliot Rankin

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Wm Mondy Rankin

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 4-1868

8. AGE: Years	Months	Days	If less than one day
71	9	8	— hrs. — min.

9. Birthplace Fremont Co. Iowa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Wilson

13. Birthplace Indiana

MOTHER 14. Maiden name Lena Goodson

15. Birthplace Indiana

16. Informant Margaret R Mondy

Address New Windsor Md.

17. (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1940 (month) (day) (year)

Cemetery or crematory —

Location Oakhaven

18. Funeral director D. O. Fackler & Sons

Address New Windsor Md.

19. Jan 14 1940 (Date rec'd by registrar) Crow E Bruce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1940, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1940, to Jan 12 1940, and that I last saw h alive on Jan 12 1940.

Immediate cause of death	DURATION
Broncho-Pneumonia	3 da
Due to Chronic Nephrocolitis	yrs.
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Mondy M. D.

M. D. or other

Address New Windsor Md Date signed 1-12-40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0439

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2months -22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Salisbury Snow Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Otis Gordy Rayne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Unknown

6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace Willards, Maryland (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Hospital Records
Address Spa. State Hosp. Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14 1940 (month) (day) (year)
Cemetery or crematory Snow Hill Cem.
Location Snow Hill, Md.

18. Funeral director C.E. Dennis
Address Snow Hill, Md.

19. Jan 11 1940 (Data rec'd by registrar) C. Harry Treen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1940, at 4:15m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 1939, to January 11 1940, and that I last saw him alive on January 11 1940

Immediate cause of death Pulmonary Tuberculosis — DURATION 4 yrs.

Due to

Due to

Other conditions

(Includa pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. M. D. or other
Address Sykesville, Md. Date signed Jan. 11-40

Information from case record to change residence to Snow Hill.
2/12/40

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FEB 5 1940
BUREAU V. S.

0440

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:

County Carroll

City or town Rural, Near New Windsor, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: x

Stay in hospital or inst. (yrs., or mos., or days) x

Stay in this community (yrs., or mos., or days) About 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Rural New Windsor Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Michael Hamilton Reaver

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Florence Harries Reaver

x 6(c) If alive, give age x years

7. Birth date of deceased (mo., day, yr.) Jan. 27th 1864

8. AGE: Years 76 | Months 11 | Days 25 | If less than one day ___ hrs. ___ min.

9. Birthplace Harney, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business x

FATHER
12. Name Ullrich Reaver
13. Birthplace Md.

MOTHER
14. Maiden name Isabelle Ott Reaver
15. Birthplace Md.

16. Informant Mrs. Eugene Wheat

Address New Windsor Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 (month) 4 (day) 40 (year)

Cemetery ~~or crematory~~ Bethel

Location Sams Creek Nr. New Windsor Md.

18. Funeral director J. E. Myers Jr.

Address Westminster, Md.

19. Jan 4 1940 (Date rec'd by registrar) Eileen S Burdett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1940, at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Dec 28 1939, to Jan 2 1940, and that I last saw him alive on Jan 1 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION 4 days

Due to Arterio-Sclerosis — ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh M.D.
M. D. or other

Address New Windsor Md Date signed 1-2-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

0441

Reg. Dist. No. 83

1. PLACE OF DEATH:
County Carroll
City or town Woodbine
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Woodbine Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Rippeon

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced —
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan. 8, 1940

8. AGE: Years — Months — Days — If less than one day hrs. min.

9. Birthplace Woodbine, Carroll Co, Md
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER
12. Name Manley R. Rippeon
13. Birthplace Carroll Co, Md.
MOTHER
14. Maiden name Mary A. Green
15. Birthplace Carroll Co. Md.
16. Informant Manley R. Rippeon
Address Woodbine Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 9, 1940 (month) (day) (year)
Cemetery or crematory Popular County.
Location Popular Springs Md.
18. Funeral director C. M. Waltz
Address Winfield, Md.
19. Jan 9 1940 (Date rec'd by registrar) Edna M. Hewitt Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1940, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,
and that I last saw h alive on 19.
Immediate cause of death
Due to Still born
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J Stanley Grabill M. D. or other
Address McAvoy Date signed 1/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

0442

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: near Uniontown Md.

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) [redacted] 8 ½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rural near Uniontown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Baby Girl Robertson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 20 - 40

8. AGE: Years | Months | Days | If less than one day 8 ½ hrs. — min.

9. Birthplace Westminster R D 3 (Town, county, and state)

10. Usual occupation Home

11. Industry or business —

FATHER 12. Name Russell Robertson

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Viola Crimminger

15. Birthplace Pensacola Florida

16. Informant Russell Robertson

Address R D 3. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 21 - 40 (month) (day) (year)

Cemetery or crematory Cemetery

Location Stone Chapel near Walnut

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. Jan. 21 19 40 Margaret R. Englar

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 19 40, at 6304 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 40, to Jan 21 19 40 and that I last saw her alive on Jan 20 19 40.

	DURATION
Immediate cause of death Premature	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md Date signed Jan 21

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FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

0443

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town near Melrose
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 9 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Melrose Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William F. Rohrbaugh

3. (b) Social Security Number 213-18-8644

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hattie E Rohrbaugh
6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar. 29. 1876

8. AGE:

Years	Months	Days	If less than one day
63	1	9	hrs. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual occupation Labor
11. Industry or business Farm + day Labor

FATHER
12. Name William H. Rohrbaugh
13. Birthplace Maryland

MOTHER
14. Maiden name Rebecca Berwager
15. Birthplace Maryland

16. Informant Mrs. Hattie E Rohrbaugh
Address Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12-1940 (month) (day) (year)
Cemetery or crematory Cemetery
Location Manchester Md

18. Funeral director Jacob Winks Sons
Address Manchester Md.

19. Jan. 11 1940 Mrs. H. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1940, at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1940, to Jan 8 1940, and that I last saw him alive on Jan 8 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 8 hrs
Due to Hypertension — 4 years
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy not

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE L. H. Denner M. D. or other
Address 230 York St. Hanover Pa Date signed 4/10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS A15

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FEB 5 1940
BUREAU V. S.

0444

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) 25 years

Stay in this community (yrs., or mos., or days) 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Wesley Ruby

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widower

6 (b) Name of ~~husband or~~ wife Sarah E Ruby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 7-1854

8. AGE: Years 85 Months 1 Days 18 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business

FATHER
12. Name John Ruby
13. Birthplace Maryland

MOTHER
14. Maiden name Rachel Sharrer
15. Birthplace Maryland

16. Informant Mrs Chas Reed
Address Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27/40 (month) (day) (year)

Cemetery or crematory St John's Lutheran

Location Carroll County

18. Funeral director Edw C Tipton
Address Hampstead Md

19. 1/26 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1940, at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 18 1940, to Jan 25 1940, and that I last saw him ~~alive~~ deed on Jan 25 1940.

Immediate cause of death Arterio Scleratic Cardio Renal Disease

Due to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: Several years

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Date signed Jan 26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 8 1949
BUREAU V. S.

0445

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: rural Finksburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 17 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Finksburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Emma Ruff

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: Felix A. Ruff

6(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): March 23 1874

8. AGE: Years	Months	Days	If less than one day
65	9	17	hrs. min.

9. Birthplace: Mt. Airy Carroll, Maryland
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER
12. Name: James F. Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Lewis
15. Birthplace: Maryland

16. Informant: Felix A. Ruff
Address: Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/12/40 (month) (day) (year)

Cemetery or crematory: Sandy Mount Cemetery

Location: Sandyville, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 1/10 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1940, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1940, to Jan 9 1940, and that I last saw her alive on Jan 9 1940.

Immediate cause of death: Arteriosclerosis (General) myocardial degeneration — DURATION

Due to: Arthritis deformans — 17 yrs.

Due to: Carcinoma left Breast multiple metastases — 2 yrs.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. Glenn Speicher
M. D. or other
Address: Westminster Date signed: Jan 10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

0446

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hosp.
Stay in hospital or inst. (yrs., or mos., or days) 22 days
Stay in this community (yrs., or mos., or days) 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3207 Avon Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas J. Sauerhoff

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Julia Quillen
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1851

8. AGE: Years 88 | Months 6 | Days 16 | If less than one day hrs. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation Shipbuilder

11. Industry or business

FATHER
12. Name Unk
13. Birthplace Baltimore Md.

MOTHER
14. Maiden name Unk
15. Birthplace Unk

16. Informant Hospital Records
Address Sykesville Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 1940 (month) (day) (year)

Cemetery or crematory
Location Sharpstown Md.

18. Funeral director Henry H. Wetzke
Address 4101 Edmondson Ave

19. Jan. 15 1940 (Date rec'd by registrar) C. Harvey Ware Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1940, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 1939, to Jan 15 1940, and that I last saw h[illegible] alive on Jan 15 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Cerebral Arterio-Sclerosis	Over 7 yrs.
Due to	
Other conditions Generalized Arterio-Sclerosis (Include pregnancy within 3 months of death)	Over 7 years.

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Max Haymon M. D. or other
Address Springfield State Hosp. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

0447

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Lyndsville Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hosp.
Stay in hospital or inst. (yrs., or mos., or days): 16 days
Stay in this community (yrs., or mos., or days): 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 3604 Clarks Lane
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Nathan Schloss

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Widowed

B (b) Name of husband or wife: Ray Symes
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 17, 1860

8. AGE:

Years	Months	Days	If less than one day
80	10	14	hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Clothing Salesman
11. Industry or business:
FATHER 12. Name: Moses Schloss
13. Birthplace: Baltimore Md.
MOTHER 14. Maiden name: Unk
15. Birthplace: Unk
16. Informant: Hospital Records
Address: Lyndsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23 1940 (month) (day) (year)
Cemetery or crematory: Bakers Hebrew
Location: Baltimore Md.
18. Funeral director: David Bondheimer
Address: 1902 Eutaw Place
19. Jan 24 1940 (Date rec'd by registrar) C Harry Weiss Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21 1940, at 4:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1940 to Jan 21 1940 and that I last saw him alive on Jan 21 1940.

Immediate cause of death	DURATION
Bronchopneumonia	8 days
Due to Pneumococcus Type III	
Due to	
Other conditions Generalized arterio-sclerosis:	10 yrs
(Include pregnancy within 3 months of death)	
Major findings: Coronary thrombosis	
Of operations	
Of autopsy	

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Max Hayman M. D. or other
Address: Springfield State Hosp. Date signed: Jan 24 1940

RECEIVED
JAN 31 1940
BUREAU OF

0448

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 mos., 29 days

Stay in this community (yrs., or mos., or days): 4 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2511 Loyola Southway (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sylvia Shapiro

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 19, 1921

8. AGE: Years: 18 Months: 7 Days: 22 If less than one day ____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Saul Shapiro
13. Birthplace: Russia

MOTHER
14. Maiden name: Anna Abrams
15. Birthplace: Lithuania

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 12 1940 (month) (day) (year)

Cemetery or crematory: Balto. Md.

Location

18. Funeral director: Sol Levinior Bros

Address: 1124 W Northern

19. Jan. 10 1940 (Date rec'd by registrar) Anthony Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 1940, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 11 1939, to Jan. 10 1940, and that I last saw her alive on Jan. 10 1940.

Immediate cause of death: Rheumatic heart disease, with mitral insufficiency and auricular fibrillation

Due to

Due to

Other conditions: Tuberous sclerosis (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 8 yrs.

manifest at 10-11 mos of age.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 1-10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1142

CERTIFICATE OF DEATH

0449

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 Mo. 24 days
Stay in this community (yrs., or mos., or days): (Same as above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Newburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Alton Smallwood

3. (b) Social Security Number: Unknown 577-18-3483

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Emma Smallwood
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): April 10, 1907

8. AGE: Years	Months	Days	If less than one day
32	9	16	____ hrs. ____ min.

9. Birthplace: Newburg, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown
FATHER 12. Name: Edward Smallwood
13. Birthplace: Newburg, Md.
MOTHER 14. Maiden name: Mary Queen
15. Birthplace: Newburg, Md.
16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/31/40 (month) (day) (year)
Cemetery or crematory: Newport
Location: Newport, Md.
18. Funeral director: Geo H Shade
Address: Waysides Md.
19. 1/26/40 (Date rec'd by registrar) Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26, 1940 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2, 1939 to January 26, 1940 and that I last saw him alive on Jan. 26, 1940

Immediate cause of death	DURATION
Acute Cardiac Failure	1 day
Due to Lung Abscess: Non-tuberculous	6 weeks
Due to --	
Other conditions	

Loose. A diagnosis of tuberculosis was not made. Cause of lung abscess could not be determined.

(Include pregnancy within 3 months of death)
Major findings: ---
Dt operations: ---
Dt autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other
Address: Henryton, Maryland Date signed 1/26/40

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FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

W 0459

107

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 26 yrs

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: ← Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.:

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ←

3. (a) FULL NAME: Fannie R. Smithson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6 (b) Name of husband or wife: ←

6(c) If alive, give age: ← years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:

Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Not any

11. Industry or business:

FATHER 12. Name: William Smithson

13. Birthplace: Germany

MOTHER 14. Maiden name: Violetta Scott

15. Birthplace: Germany

16. Informant: Laura Lundquest

Address: Jessup Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1940 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem

Location: Sykesville Md.

18. Funeral director: C. S. Wear

Address: Sykesville Md.

19. Jan 6 1940 (Date rec'd by registrar) C. S. Wear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4th 1940, at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1938, to Jan 4th 1940, and that I last saw her alive on Jan 4th 1940.

Immediate cause of death	DURATION
Broncho Pneumonia	Dec 15/38
Due to	
Due to Epilepsy	40 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: No

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M. D. or other

Address: Sykesville Md. Date signed: Jan 6/40

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FEB 15 1940
BUREAU V. S.

0451

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster - Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster - Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Florence Belle Snader

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Elwood E. Snader

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 28 1871

8. AGE: Years 68 Months 57 Days 20 If less than one day ____ hrs. ____ min.

9. Birthplace: New Windsor Carroll Co Md
(Town, county, and state)

10. Usual occupation: House wife at home

11. Industry or business:

FATHER
12. Name: Dean Husbaum
13. Birthplace: Carroll Co Md

MOTHER
14. Maiden name: Margaret Naile
15. Birthplace: Carroll Co Md

16. Informant: David Snader
Address: Westminster Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jan 21-40 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Near Uniontown Md

18. Funeral director: D D Hartzler & Sons

Address: New Windsor Md

19. 1/19 1940 L K Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1940, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 1939, to Jan 18 1940, and that I last saw her alive on Jan 18 1940.

Immediate cause of death: Pneumonia Broncho — DURATION: 1 wk.

Due to: Myocardial Degeneration, Cerebral Fibrillation & Mitral Insufficiency

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster Md Date signed: Jan 19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0452

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 10 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1634 Miller Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Emerson James Stanley

3. (b) Social Security Number: 217-10-8465

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): May 23, 1912

8. AGE: Years	Months	Days	If less than one day
27	8	3	---hrs. ---min.

9. Birthplace: Cambridge, Maryland (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: Unknown

FATHER — 12. Name: Alfred F. Stanley
13. Birthplace: Airey, Md.

MOTHER — 14. Maiden name: Laura Height
15. Birthplace: Airey, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/40 (month) (day) (year)

Cemetery or crematory: Wards Cemetery

Location: Cambridge, Md.

18. Funeral director: Harry F. Vodery

Address: 224 High St.

19. 1/26/40 (Date rec'd by registrar) 19 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26, 1940 19 , at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16, 1940 19 to Jan. 26, 1940 19 and that I last saw him alive on Jan. 26, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1939

Due to: ---

Due to: ---

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --- (City or town) --- (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed 1/26/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0453

Reg. Dist. No. 7-4

1. PLACE OF DEATH:

County Carroll

City or town Sykesville - Md -

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 14 yrs 1 day

Stay in this community (yrs., or mos., or days) Life -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Seneca, Boyd Station Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Louise Steward

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Willard G. Steward

6(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) May 31 - 1876

8. AGE:

Years	Months	Days	If less than one day
63	7	14	hrs. min.

9. Birthplace Maryland - Montgomery -

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Thomas D. Darby -

13. Birthplace Montgomery County - Md -

MOTHER

14. Maiden name Elizabeth Dawson -

15. Birthplace Montgomery County, Md -

16. Informant Hospital Records.

Address Sykesville, Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/40 (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville, Md

18. Funeral director William B. Wilson

Address Barnesville, Md

19. January 15 1940 C. Harvey Wines

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1940, at 10:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16 1926, to January 14 1940, and that I last saw h-er alive on January 14 1940 -.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec 27-39
Due to Tuberculous Pneumonia	Jan 3-'40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. -

M. D. or other

Address Sykesville, Md Date signed Jan. 14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

0454

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Finksburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 4½ years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Finksburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Atlee Ray Stocksdale

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 7, 1935

8. AGE:

Years	Months	Days	If less than one day
4	5	28	____ hrs. ____ min.

9. Birthplace: Finksburg, Carroll, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Howell K. Stocksdale
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sadie M. Abbott
15. Birthplace: Maryland

16. Informant: Howell K. Stocksdale
Address: Finksburg, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1/6/40 (month) (day) (year)

Cemetery or crematory: Finksburg Cemetery

Location: Finksburg, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 1/6 1940 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4, 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-22-39 19__, to 1-4-1940, and that I last saw him alive on 1-4-40 19__

Immediate cause of death: Influenza — DURATION 12-22-39; 1-4-40
Pericarditis (Acute) — 1-1-40
Asthma, — 1-4-40
Due to: Broncho pneumonia — 12-28-39; 1-4-40; 12-23-39; 12-27-39

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. C. Jermette M.D.
M. D. or other
Address: Westminster Md. Date signed 1-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

0455

Reg. Diat. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster Rural Near
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Rural Near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Iva Mae Swartzbaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife William B. Swartzbaugh
6(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Dec. 15 1917

8. AGE:

Years	Months	Days	If less than one day
22	0	28	hrs. min.

9. Birthplace Near Union Bridge, Carroll, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William B Bowers
13. Birthplace Maryland

MOTHER
14. Maiden name Iva Mildred Harris
15. Birthplace Maryland

16. Informant William B. Swartzbaugh
Address Westminster, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15. 1940 (month) (day) (year)
Cemetery or crematory Deer Park Cemetery
Location Smallwood
18. Funeral director H Barnhart & Son
Address Westminster Maryland
19. 1/15 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13-1940, at 5:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10-1940, to 1-13-1940, and that I last saw her alive on 1-13-40 1940.

Immediate cause of death	DURATION
Diphtheria	1-12-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.
M. D. or other
Address Westminster Date signed 1-14-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0456

Reg. Dist. No. 74

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 6 days

Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester Co.

City or town: Cambridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 412 High Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: James William Sweets

3. (b) Social Security Number: 212-10-8031

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Hattie Sweets

6(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1901

8. AGE: Years	Months	Days	If less than one day
38	4	15	---hrs. ---min.

9. Birthplace: Sulfolk, Va.
(Town, county, and state)

10. Usual occupation: Bar Tender

11. Industry or business: Unknown

FATHER 12. Name: William Sweets

FATHER 13. Birthplace: North Carolina

MOTHER 14. Maiden name: Anne Darden

MOTHER 15. Birthplace: ?

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/27/40 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem

Location: Balto Md

18. Funeral director: Isaiah L Brown Sons

Address: 1086 Montgomery St

19. 1/24/40 (Date rec'd by registrar) 19 Albert R Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24, 1940 6:30 P.M. 19 ..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18, 1940 19 to Jan. 24, 1940 19, and that I last saw him alive on Jan. 24, 1940 19

Immediate cause of death: Cardiac Failure — DURATION: 1 Mo.

Due to: Pulmonary Tuberculosis — May; 1938

Due to: ---

Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 1/24/40

RECEIVED
FEB 5 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0457

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or instn. (yrs., or mos., or days): 10 days
Stay in this community (yrs., or mos., or days): 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 18 Continental St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: David Tennant

3. (b) Social Security Number: Possd. - 187-01-7744

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

8 (b) Name of husband or wife: Bertha Kyle
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1877

8. AGE: Years: 62 | Months: 10 | Days: | If less than one day: hrs. min.

9. Birthplace: Pelsin, Md
(Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business:

FATHER
12. Name: David Tennant
13. Birthplace: Scotland, British Isles

MOTHER
14. Maiden name: Agnes Campbell
15. Birthplace: Scotland, British Isles

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 31, 1940 (month) (day) (year)
Cemetery or crematory: Frostburg
Location: Frostburg Md.

18. Funeral director: C. A. Keen
Address: Sykesville Md.

19. Jan. 30 1940 (Date rec'd by registrar) C. Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1940, at 6½ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 20 1940, to Jan 30 1940, and that I last saw h- alive on Jan 30 1940.

Immediate cause of death: Erysipelas of Face & Chest. — DURATION: Jan 26 1940

Due to:

Due to:

Other conditions: Bronchopneumonia — Jan 27 1940
Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Chas Hayman M. D. or other
Address: Springfield State Hosp. Date signed 1/30/40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 81c

0458

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural Union Bridge (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Carroll

(c) City or town Rural Union Bridge (If outside city or town limits, write RURAL and give town)

(d) Street No. Priestland (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** William Melville Toyer

3 (b) If veteran, name war: None

3 (c) Social Security No. 216-05-1796

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Naomi Toyer

6. (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1878

8. **AGE:** Years 61 | Months 11 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Union Bridge Frederick Co. Md (Town, county, and state)

10. Usual occupation Water Tender

11. Industry or business Cement Plant

FATHER

12. Name Baston Toyer

13. Birthplace Union Bridge, Frederick Co. Md

MOTHER

14. Maiden Name Mary Jane Dumon

15. Birthplace Union Bridge, Frederick Co. Md

16 (a) Informant Mrs. Naomi Toyer

(b) Address Union Bridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23 1940 (month) (day) (year)

(c) Cemetery or crematory Mt Joy Cem.

Location Hyattstown, Md.

18 (a) Funeral director D. D. Hoyle & Son

(b) Address Union Bridge, Md.

19 (a) Jan. 23, 1940 (Date rec'd by registrar) (b) R. Richardson Deputy Registrar

MEDICAL CERTIFICATION

20. Date of death Jan 20 1940, at 6 45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1940, to 1-20-1940, and that I last saw him alive on 1-17-1940.

Immediate cause of death	Duration
Cerebral Embolism	sudden
Due to	
Due to Endocarditis & Chronic Duration: three years	Cor. & R.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** J. H. Legg M. D. or other

Address 1-22-40 Union Bridge Md. Date signed

RECEIVED
FEB 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-c)

0459

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 133½ Pennsylvania Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 133½ Pennsylvania Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George H. Troxell

3. (b) Social Security Number 212035360

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

8 (b) Name of ~~husband or~~ wife Rhoda C. Yeiser

6(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1909

8. AGE: Years 30 Months 4 Days 12 If less than one day ___ hrs. ___ min.

9. Birthplace Mt. Pleasant Carrol. Maryland
(Town, county, and state)

10. Usual occupation Pullover.

11. Industry or business Shoe Factory

FATHER
12. Name Moses J. M. Troxell
13. Birthplace Md.

MOTHER
14. Maiden name Cora M. Yeiser
15. Birthplace Md.

16. Informant Mrs Rhoda C. Troxell

Address 133½ Penn. Ave. Westminster Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Jan. 26. 1940
(month) (day) (year)

Cemetery or ~~crematory~~ Kriders

Location Nr. Westminster Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 1/25 1940 J. K. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1940, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1940, to Jan 23 1940, and that I last saw him alive on Jan 23 1940

Immediate cause of death Korsakoffs Psychosis — DURATION 1 year

Due to Chronic alcoholism — ?

Due to

Other conditions Wasserman Positive — 2 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford M Taylor MD
M. D. or other

Address Westminster Date signed 1-24-40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 2 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

0460

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 13 Ward Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 63 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 13 Ward Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Moses J. M. Troxell

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Cora M. Yeiser
6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): February 4, 1876

8. AGE: Years	Months	Days	If less than one day
63	11	20	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: State road maintenance
11. Industry or business:

FATHER
12. Name: Henry T. Troxell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maria Lippy
15. Birthplace: Maryland

16. Informant: Benjamin F. Troxell
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 27, 1940 (month) (day) (year)
Cemetery or crematory: Silver Run Reformed Cem.
Location: Silver Run, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 1/24 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 1940, at 12a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1940 to Jan 24 1940, and that I last saw h[illegible] alive on Jan 23, 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 hrs.
Due to Hypertensive Cardiovascular disease	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clifford H. Taylor, M. D. or other
Address: Westminster Date signed 1-24-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

0461

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 46 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Clayton Turner

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma A. Turner
6(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Dec. 3. 1859

8. AGE: Years 80 | Months 1 | Days 11 | If less than one day ____ hrs. ____ min.

9. Birthplace Hampstead Md
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Gen. Store

FATHER
12. Name Jacob Turner
13. Birthplace Hampstead Md

MOTHER
14. Maiden name Rebecca Murray
15. Birthplace Maryland

16. Informant Mrs. T. C. Turner
Address Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-17-40 (month) (day) (year)
Cemetery or crematory Cemetery
Location Manchester, Md

18. Funeral director Jacob Weinbergs Sons
Address Manchester Md

19. Jan. 16 1940 Mrs. W. R. S. Dennis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1940, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1940, to ____ 19____, and that I last saw him alive on Jan 14 1940.

Immediate cause of death Coronary Sclerosis — DURATION Sudden

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William R. S. Dennis M. D. or other
Address Manchester Md Date signed 1/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-a)

CERTIFICATE OF DEATH

0462

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taylorsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hosp.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Prince George

City or town Upper Marlboro Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME L. Jettie Ware

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 78 | Months | Days | If less than one day hrs. min.

9. Birthplace Upper Marlboro Md (Town, county, and state)

10. Usual occupation

11. Industry or business Not any

FATHER 12. Name James D. Ware

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Dolley

MOTHER 15. Birthplace Unknown

16. Informant Co. Com. Prince George Md

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10 1940 (month) (day) (year)

Cemetery or crematory Springfield Hosp. Cem.

Location Taylorsville Md.

18. Funeral director C. A. Heer

Address Taylorsville Md.

19. Jan. 6 1940 (Date rec'd by registrar) C. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4th 1940, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1935, to Jan 4th 1940, and that I last saw her alive on Jan 4th 1940.

Immediate cause of death — DURATION

Cerebral Hemorrhage — Jan 4th

Due to — Arterio Sclerosis — 20 yrs

Other conditions — Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE W. G. Gaston M. D. or other

Address Taylorsville Date signed Jan 6 1940

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0463

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 3 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Baltimore City~~ Baltimore
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1311 Whatcoat Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Margaret Murray Watts

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	col.	married

6 (b) Name of husband or wife: Reed Watts
6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1920

8. AGE: Years	Months	Days	If less than one day
19	2	5	____ hrs. ____ min.

9. Birthplace: Bellevue, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: --

FATHER
12. Name: Thomas Murray
13. Birthplace: Bellevue, Md.

MOTHER
14. Maiden name: Eleanor Goldsberg
15. Birthplace: Bellevue, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-10-40 (month) (day) (year)
Cemetery or ~~crematory~~: Mt. Calvary
Location: A. A. Co.
18. Funeral director: Saml. W. Crane & Son
Address: 638 N. Gilmor St.

19. 1/17/40 (Date rec'd by registrar) Albert R Swankhaus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 7 1940, 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4, 1940 to Jan. 7 1940, and that I last saw her alive on Jan. 7 1940.

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs. 4 mos.
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Md. Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 10 1940
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0464

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 4 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3428 Ash Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Fannie Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1850

8. AGE: Years	Months	Days	If less than one day
89	4	16	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Mill worker
11. Industry or business
FATHER 12. Name Thomas Wilson
13. Birthplace Virginia
MOTHER 14. Maiden name Julia Reid
15. Birthplace Virginia
16. Informant Miss Elsie Pierce
Address 5141 Wetheredsville Rd, Dickeysville, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 11, 1940 (month) (day) (year)
Cemetery or crematory St. Mary's Cemetery, Hampden
Location Dalton Rd
18. Funeral director Wm. J. Tribunes & Son
Address North Pa Ave Balto Md
19. Jan 9 1940 C Harry Steer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH N January 9 1940, at 11:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1940 to Jan. 9 1940 and that I last saw her alive on Jan. 9 1940

Immediate cause of death	DURATION
Arteriosclerosis	More than 10 yrs.
Due to Chronic Myocarditis and Myocardial Degeneration-with	known
Due to Pulmonary edema	1-5-40
	1-5-40
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other
Address Sykesville, Md Date signed Jan. 9-40

RECEIVED
FEB 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0465

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 Yr. 8 Mo. 15 Days.
Stay in this community (yrs., or mos., or days): (Same As Above.)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1802 Maryland Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Lewis Wilson

3. (b) Social Security Number: 579-09-6302

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Sadie Wilson
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): March 9, 1908

8. AGE:

Years	Months	Days	If less than one day
31	9	29	____ hrs. ____ min.

9. Birthplace: Lynchburg, Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Shultz Wilson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mildred Carter
15. Birthplace: Lynchburg, Va.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9 1940 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cemet.
Location: Mt Winans

18. Funeral director: E O Wilson
Address: 1004 Brantley

19. 1/8/40 (Date rec'd by registrar) 19__ Albert R Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 8, 1940 1:10 P.M. 19__, at __M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1938 19__, to Jan. 8, 1940 19__, and that I last saw him alive on Jan. 8, 1940 19__

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1937
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 1/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 10 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0466

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr. 5 mo. 22 days

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ellsworth Youtkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 8, 1913

8. AGE:

Years	Months	Days	If less than one day
26	7	10	hrs. min.

9. Birthplace: Weverton, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER 12. Name: Oliver M. Youtkins

FATHER 13. Birthplace: Washington Co., Md.

MOTHER 14. Maiden name: Emma Hoffman

MOTHER 15. Birthplace: Washington Co., Md.

16. Informant: Mrs. Eva Medinger

Address: 1253 N. Bentalou St. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20, 1940 (month) (day) (year)

Cemetery or crematory: Brownsville

Location: Brownsville Md.

18. Funeral director: L. L. Eachles

Address: Bolivar, West Va.

19. Jan 18 1940 (Date rec'd by registrar) O. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1940, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1938, to January 18, 1940, and that I last saw him alive on January 17, 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 6 1939

Due to: Tuberculous Peritonitis — Jan. 15-40

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy As above

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

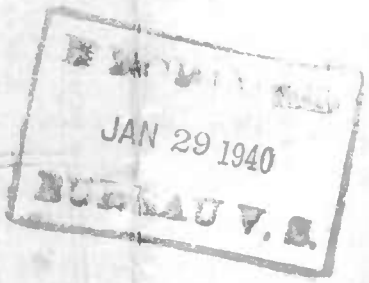
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. (M. D. or other)

Address: Sykesville, Md. Date signed Jan. 15-40


JAN 29 1940
BUREAU U. S.